A PUBLIC HEALTH PERSPECTIVE ON HEALTH CARE REFORM

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"We don't have a health care system in America. We have a sick care system. If you get sick, you get care. But precious little is spent to keep people healthy in the first place."

-- *Sen. Tom Harkin (D-IA)*[1]

INTRODUCTION

The two pieces of health care reform legislation signed by President Obama in March 2010, the Patient Protection and Affordable Care Act (Affordable Care Act or Act) and the Health Care and Education Reconciliation Act, will provide millions of Americans with access to affordable—or at least more affordable—health insurance and limit the ability of insurance companies to deny needed care. With more than forty-six million Americans uninsured[2] and the cost of insurance premiums skyrocketing, significant federal action to expand health insurance coverage and make it more affordable was long overdue.

But in 2009 and 2010, as Congress considered (and reconsidered and reconsidered) a fundamental restructuring of the health care industry, one question was notably missing from the national debate: how can we keep people from getting sick? Although "bending the cost curve" became a frequently-repeated catchphrase, the focus was on reducing the cost of medical *treatment*, not on preventing or reducing the *occurrence* of chronic diseases. This omission from the public debate was regrettable because chronic disease prevention must be a

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[1] Robert Pear, *New Health Initiatives Put Spotlight on Prevention*, N.Y. TIMES, April 5, 2010, at A10.

[2] KAISER FAMILY FOUNDATION, THE UNINSURED: A PRIMER, 1 (2010), http://www.kff.org/uninsured/upload/7451-06.pdf.

primary goal if we are to successfully improve health and reduce health care costs.

Obesity-related conditions, alcohol use, and tobacco consumption are together responsible for nearly 40 percent of the deaths in the U.S. each year.[3] Yet for the most part, these are problems that "do not arise from lack of medical care, cannot be solved by medical care, and can lead to fatal diseases and conditions for which medical care can do very little."[4] Thus, effective health care reform must move beyond the doctor's office and consider how to prevent disease by promoting and supporting healthy living.

Although disease prevention was virtually ignored during the public debate over health care reform, it was addressed in the text of the Affordable Care Act.[5] Title IV of the Affordable Care Act, entitled "Prevention of Chronic Disease and Improving Public Health," contains more than two dozen programs and new laws geared towards "modernizing disease prevention and the public health system," "increasing access to clinical preventive services," "creating healthier communities," and "support[ing] prevention and public health innovation."[6] According to Sen. Tom Harkin (D-IA), the lead author of many of these provisions, the goal of Title IV was to reorient our system from being a "sick care system" to being a "health care system" by "creating a sharp new emphasis on disease prevention and public health."[7]

"Disease prevention and public health," however, are not self-defining concepts. What is meant by disease prevention? How can such prevention best be accomplished? Who has the responsibility—and the ability—to protect the public's health? These are questions that public health scholars have studied and debated for decades, without agreeing on the answers. Some public health scholars emphasize "proximate risk factors, potentially controllable at the individual level," [8] while others highlight "more fundamental, distal causes of

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[3] Thomas A. Farley, *Reforming Health Care or Reforming Health?*, 99 AM. J. PUB. HEALTH 588, 589 (2009).

[4] *Id.* (internal parenthetical omitted).

[5] Because of the rules limiting the issues that could be addressed in the reconciliation process, the Health Care and Education Reconciliation Act did not amend the prevention-related pieces of the Affordable Care Act.

[6] These are the titles of various sub-sections of Title IV. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1(b), 124 Stat. 119, 124 (2010).

[7] Sen. Tom Harkin, *Op-Ed Contributor: Shifting America from Sick Care to Genuine Wellness*, YAHOO! NEWS (June 25, 2009, 3:21 AM), http://news.yahoo.com/s/ynews/20090625/ts_ynews/ynews_ts408.

[8] Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. (EXTRA ISSUE) 80, 80 (1995).

disease that may include socioeconomic status, as well as other social and environmental factors, such as social cohesion or even legal structures."[9] With different interpretations of the term "prevention" competing for dominance in the intellectual realm, it becomes important to examine the conception of preventive health that is embodied by and reflected in our legal system. As the Affordable Care Act is the most dramatic reworking of our health-related laws in decades, it provides a perfect opportunity to examine how the law constructs and codifies the concept of public health. Understanding the paradigm of public health that the Affordable Care Act has adopted provides a basis for critically reanalyzing that paradigm and discussing how the legal system might better incorporate the lessons that have been learned by public health experts.

This Article seeks to use the text of the Affordable Care Act's prevention-oriented provisions as a starting point for an exploration of the paradigm of prevention that is embodied by the law. Ultimately, I argue that the understanding of public health reflected in the Act is too narrow and does not comport with the way that most public health experts conceptualize their field.

Section I of the Article begins by examining two opposing paradigms that shape perspectives of public health. The first is the "individualist/biomedical paradigm" that conceives preventive health in highly individualistic and medicalized terms. Since "[m]ost illness and premature deaths are caused by human habits of living that people choose for themselves,"[10] this paradigm assigns the primary responsibility for prevention to individuals, who should be urged to make more responsible and healthier choices about what they consume and how they live. In addition, since not all disease can be prevented, the "biomedical" portion of the individualist/biomedical paradigm emphasizes the importance of screening and testing that can identify disease at an early stage and thereby facilitate more effective treatment. The competing "public health paradigm" employs the tools of social epidemiology and emphasizes that people's choices are profoundly influenced and limited by the social and environmental context in which they live. This paradigm draws attention to stark health disparities between populations—whether defined by geography, socioeconomic status, or otherwise—to critique the viewpoint that health is largely determined on an individual level. I then discuss how these

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[9] WENDY E. PARMET, POPULATIONS, PUBLIC HEALTH, AND THE LAW 13 (2009). This latter category of scholars has emphasized the "ubiquitous and often strong association between health and socioeconomic status." Link & Phelan, *supra* note 8, at 81.

[10] John K. Iglehart, *From the Editor*, HEALTH AFF., May 1990, at 4, 4.

two paradigms lead to very different understandings of the term "prevention" and the appropriate target of public health interventions. From the perspective of the individualist/biomedical paradigm, prevention should focus on altering individual decision-making, while the public health paradigm suggests that "it may be more efficient to try to change the social environment that influences people to behave in unhealthy ways than to try to change people's behavior one individual at a time."[11]

Section II then looks to the text of the Affordable Care Act to uncover the paradigm of prevention that is embodied in the text. This section focuses on three different categories of initiatives: information awareness campaigns, efforts to increase access to clinical preventive services, and workplace wellness programs. I conclude that these types of initiatives, which collectively account for a large portion of the prevention-oriented provisions in the Act, all reflect an understanding of prevention shaped by the individualist/biomedical paradigm. These provisions therefore attempt to alter individual decision-making while leaving the broader social and environmental context unchanged.

Finally, Section III briefly concludes the Article by asking why the provisions in the Act differ so dramatically from the recommendations of public health experts and suggesting pathways for future research.

I. THE INDIVIDUALIST/BIOMEDICAL PARADIGM AND THE PUBLIC HEALTH PARADIGM

A. The Individualist/Biomedical Paradigm

The "individualist/biomedical paradigm" has two components. The first is a reliance on—and a pervasive belief in the nearly limitless power of—biomedical technology.[12] The belief that medical research can identify the source of any health problem and provide a pill or a procedure to fix it is an underlying premise of a typical medical school education, and it is a belief that influences most interactions between health care providers and patients.[13] In general, doctors talk

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[11] MARY-JANE SCHNEIDER, INTRODUCTION TO PUBLIC HEALTH 226 (3d. ed. 2011).

[12] *See* Charles E. Rosenberg, *Anticipated Consequences*, *in* HISTORY AND HEALTH POLICY IN THE UNITED STATES 13, 18 (Rosemary A. Stevens et al. eds., 2006).

[13] Our spending decisions relating to health reflect a focus on the search for biomedical cures. Collectively, the U.S. government, U.S.-based foundations, and U.S.-based corporations account for more than two-thirds of the world's biomedical

to their patients about how to identify and treat their problems, with little discussion of preventive health.[14] This biomedical model has been influential in the world of preventive health.[15] Indeed, using testing and screening to search for chronic disease has, in the words of one expert, "become a cultural norm."[16] With testing and screening technology that improves by the day, and with advocacy groups and heath experts recommending an ever-growing battery of tests, "early detection [though screening and testing] has become the dominant cancer prevention strategy in mainstream American medicine."[17]

The second prong of the individualist/biomedical paradigm is the assumption that maintaining one's good health is primarily an individual's own responsibility. Or, as it is often phrased, "Americans need to take personal responsibility for their health care."[18] In recent decades, as there has been a growing recognition that "behavioral risk factors" such as poor nutrition, lack of physical activity, and tobacco use are major causes of chronic disease, there have been growing calls for individuals to either take greater responsibility for their own health or bear their own medical costs. These challenges to health are seen as problems or temptations that each individual must confront; good health is viewed as the triumph of willpower and restraint, while obesity and tobacco use are socially constructed as signs of laziness, weakness, or even low intelligence.[19] As Howard Leichter has chroni-

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research (compared to approximately one-third of other types of research and development). E. Ray Dorsey et al., *Funding of US Biomedical Research, 2003-2008*, 303 JAMA 137, 141 (2010).

[14] An exception to the general rule is provided by medical-legal partnerships, which train doctors to recognize social and environmental conditions that threaten the health of their patients. *See, e.g.*, David I. Schulman et al., *Public Health Legal Services: A New Vision*, 15 GEO. J. ON POVERTY L. & POL'Y 729, 758-66 (2008).

[15] *See* Ann Robertson, *Shifting Discourses of Health in Canada: From Health Promotion to Public Health*, 13 HEALTH PROMOTION INT'L 155, 155 (1998) ("Discourses on health include the ideas we have about, and the explanations we offer for, what health is and what determines it, as well as the particular practices that are produced by these ideas. Biomedicine represents the most successful discourse on health, at least in the Western industrialized world.").

[16] H. GILBERT WELCH, SHOULD I GET TESTED FOR CANCER? 5 (2004).

[17] *Id.* at 3. The same point can be applied to the prevention of other types of chronic disease.

[18] Amy B. Monahan, *The Promise and Peril of Ownership Society Health Care Policy*, 80 TUL. L. REV. 777, 805 (2006).

[19] *See, e.g.*, Rogan Kersh & James A. Morone, *Obesity, Courts, and the New Politics of Public Health*, 30 J. HEALTH POL. POL'Y & L. 839, 847 (2005) ("From the nation's Puritan start, Americans have read health and wealth as marks of personal virtue. Some people work hard to maintain a healthy lifestyle, on this view, and they reap the benefits of their virtue: good health, better social lives, and additional happiness. The inevitable downside sees obesity (like smoking, heavy drinking, or poverty)

cled, this viewpoint has deep historical roots. Early twentieth century theorists believed that "as a result of ignorance, laziness, immorality, or lack of willpower, too any Americans made foolish, self-harming, and socially costly behavioral choices."[20]

Not only is "personal responsibility" rhetoric a "distinguishing feature[] of American culture and politics,"[21] but according to psychologists, it also has psychological roots:

> [A] principle finding from many related fields of social, cognitive, neural, and behavioral psychology is that our intuitions and observations, together with deeply laden psychological motivations, lead us to attribute behavior largely to the dispositions of individuals (privately ordered preferences, interests, and intentions), to the exclusion of appreciating the powerful part that external situation plays in influencing human behavior. Situational influences tend to be opaque to our conscious thinking about the sources of our choices. Many names in different literatures describe this core insight, and often refer to it as "the fundamental attribution error" or "dispositionism."[22]

Under the influence of dispositionism, people tend to attribute negative events that happen to themselves to external forces, while seeing bad things that happen to others as the result of their own choices or weaknesses.[23]

The influence of dispositionism helps to explain prevailing attitudes towards, for example, obesity. It is no coincidence that "[t]he steep rise in obesity [has followed] closely on the heels of significant changes to the food supply."[24] For the first time in human history, we are surrounded by cheap, easily-available, and pervasively advertised high-calorie, high-fat foods that thousands of years of evolution have

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as personal failures. Obese people have no one to blame but themselves.") (citation omitted).

[20] Howard M. Leichter, *"Evil Habits" and "Personal Choices": Assigning Responsibility for Health in the 20th Century*, 81 MILLBANK Q. 603, 607 (2003). And as suggested by Kersch & Morone, *supra* note 19, this viewpoint can be traced back substantially further in American history.

[21] Leichter, *supra* note 20, at 604.

[22] David G. Yosifon, *Legal Theoretic Inadequacy and Obesity Epidemic Analysis*, 15 GEO. MASON L. REV. 681, 684-85 (2008) (footnotes omitted) (internal punctuation omitted).

[23] Marlene B. Schwartz & Kelly D. Brownell, *Actions Necessary to Prevent Childhood Obesity: Creating the Climate For Change*, 35 J.L. MED. & ETHICS 78, 84-85 (2007).

[24] Barbara L. Atwell, *Obesity, Public Health, and the Food Supply*, 4 IND. HEALTH L. REV. 1, 4 (2007).

conditioned us to over-consume when available. [25] But despite the powerful biological, psychological, social, and environmental influences on food consumption, "the most popular explanation for obesity is in the individual failure of people to eat less and exercise more."[26] Although it should be obvious that "the rise in obesity over the past two decades has not been caused by a sudden upsurge in moral failure among Americans,"[27] the obese are regularly blamed for their own condition and stereotyped as "dishonest, sloppy, ugly, socially unattractive, less productive, lazy, stupid, and worthless."[28]

Importantly, the dispositionalist framing that attributes poor health to a "failure of personal responsibility" is not only a logical product of the individualist/biomedical paradigm, but it is also strategically deployed by industries that contribute to poor health:

> The food industry [as well as the alcohol and tobacco industries] promotes this view of consumer behavior to courts, government, legal theorists, and to consumers themselves. Indeed, much corporate speech is dedicated to the promotion of dispositionism, which, it turns out, is an extremely effective strategy in the court of public opinion, and in government.[29]

David Yosifon and Jon Hanson refer to this process as "deep capture," to emphasize that industries have, in many cases, successfully "captured" not only the regulatory agencies responsible for their oversight ("shallow capture"), but "the terms by which the situation is evaluated

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[25] Adam Benforado, Jon Hanson & David Yosifon, *Broken Scales: Obesity and Justice in America*, 53 EMORY L.J. 1645, 1687 (2004).

[26] J. Eric Oliver & Taeku Lee, *Public Opinion and the Politics of Obesity in America*, 30 J. HEALTH POL. POL'Y & L. 923, 947 (2005).

[27] *Id.*

[28] Jane Korn, *Too Fat*, 17 VA. J. SOC. POL'Y & L. 209, 222 (2010).

[29] David G. Yosifon, *Resisting Deep Capture: The Commercial Speech Doctrine and Junk-Food Advertising to Children*, 39 LOY. L.A. L. REV. 507, 591 (2006); *see also* MARION NESTLE, FOOD POLITICS 360 (2d ed. 2007) ("The emphasis on individual choice serves the interests of the food industry for one critical reason: if diet is a matter of individual free will, then the only appropriate remedy for poor diets is education, and nutritionists should be off teaching people how to take personal responsibility for their own diet and health—not how to institute societal changes that might make it easier for everyone to do so."). Another example: tobacco companies run television ads purportedly for the purpose of smoking prevention that encourage parents to explain to their children that smoking is an "adult choice" and that they should resist peer pressure to smoke. These ads construct smoking as purely an individual decision, ignoring the tobacco industry's role in marketing cigarettes and engineering them to create and sustain addiction. *See generally* Anne Landman et al., *Tobacco Industry Youth Smoking Prevention Programs: Protecting the Industry and Hurting Tobacco Control*, 92 AM. J. PUB. HEALTH 917 (2002).

and understood."[30] Where successful, this "deep capture" solidifies in policymakers' minds (and the public's mind) an individualist perspective that ignores the role of industries is creating and perpetuating public health problems.

B. The Public Health Paradigm

A competing "public health paradigm," now the dominant paradigm applied by public health scholars (though not the dominant paradigm in the public sphere), views health from a population-based perspective. As Mary-Jane Schneider writes, "While medicine is concerned with individual patients, public health regards the community as its patient, trying to improve the health of the population."[31] This perspective "emphasizes the environmental and social determinants of health and how they effect the well-being of populations [and not just individuals]," and starts with the premise that many important aspects of health cannot be controlled in the doctor's office.[32]

Wendy Parmet writes:

> [T]he population perspective reminds us that the levels of risk that an individual faces are always determined, at least in part, and often in large measure, at a population level. Thus though an individual may be able to choose what treatment to accept or reject after a terrible car accident, the individual cannot fully control the risk that he or she faces by driving. Nor can a lone individual control the risk that a natural disaster will devastate a city. As a result, the most critical choices, such as lowering the risk of disease or injury, can never be realized solely be recognizing individualistic rights.[33]

Applying this perspective, public health scholars have recognized that tobacco use, obesity, violence, and other public health challenges, even though they are typically considered by the dominant individual-

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[30] Jess Alderman et al., *Application of Law to the Childhood Obesity Epidemic*, 35 J.L. MED. & ETHICS 90, 102 (2007); *see also* Jess Alderman, *Words to Live By: Public Health, the First Amendment, and Government Speech*, 57 BUFF. L. REV. 161, 212 (2007) ("The term 'deep capture' refers to a scenario in which an outside entity has a powerful influence not only over the situation but also over the way in which the situation is analyzed and perceived.").

[31] SCHNEIDER, *supra* note 11, at 6.

[32] PARMET, *supra* note 9, at 17. Parmet's book is a sustained argument that this "population perspective" should be considered a "legal norm" and that judges should reshape their understanding and approach to legal doctrine ways that would "treat[] protection of population health as an important legal goal." *Id.* at 62-65.

[33] *Id.* at 159.

ist/biomedical paradigm in primarily individualistic terms, are substantially influenced by population-level socioeconomic, cultural, environmental, and legal structures.

Researchers applying a public health paradigm also seek to uncover the social and environmental factors that lead to health disparities (whether along socioeconomic, racial, gender, or other lines).[34] For example, Mary-Jane Schneider writes that "[i]n the United States today, the health of the poor is threatened by the adverse environmental conditions of the inner cities, such as lead paint and air pollution, crime, and violence," not to mention a lack of affordable nutritional options, disproportionate targeting by the fast food, tobacco, and alcohol industries, and limited opportunities for safe physical activity.[35] The public health paradigm illuminates these environmental challenges to community health, while an overly individualistic perspective is by definition insensitive to population-based disparities.

C. Paradigms and Prevention

These two different paradigms—the individualist/biomedical paradigm and the public health paradigm—lead to very different understandings of "prevention" and very different policy approaches to preventive health. Indeed, when public health experts and policymakers talk about "prevention," they may be using the same word but talking about very different concepts. Health scholars have identified three different levels of prevention: primary, secondary, and tertiary.

- *Primary prevention* "prevents an illness or injury from occurring at all, by preventing exposure to risk factors."[36]

- *Secondary prevention* detects disease at an early stage, before the disease has become symptomatic, using medical testing and screening.

- *Tertiary prevention* seeks to prevent a worsening of symptoms in an individual already suffering from an ailment or disorder.[37]

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[34] Public health experts have long recognized the "strong and consistent finding of epidemiological research . . . that socioeconomic status (SES) is correlated with morbidity, mortality, and functioning." Lawrence O. Gostin, *Forward, Socioeconomic Disparities in Health: A Symposium on the Relationships Between Poverty and Health*, 15 GEO. J. ON POVERTY LAW & POL'Y 571, 571 (2008).

[35] SCHNEIDER, *supra* note 11, at 226.

[36] *Id.* at 12.

When public health experts speak about prevention, they are often talking about primary prevention interventions that would seek to prevent diseases from occurring. They are of course concerned with secondary and tertiary prevention as well, but their population-based orientation leads to an emphasis on primary prevention. By contrast, when policymakers speak about prevention and write laws, the emphasis is often different, steeped in a much narrower conception of prevention.

Under the individualist/biomedical paradigm, discussions of "preventive health" often focus on secondary and tertiary preventive services that help to identify disease (or risk factors for disease, such as hypertension) at an early stage and keep it from getting worse (by, for example, prescribing blood-pressure medication). As discussed below, a major part of Title IV of the Affordable Care Act reflects this understanding of preventive health and deals with expanding access to secondary preventive services such as screening and testing.

To the extent that the individualist/biomedical paradigm allows for a consideration of primary prevention, the responsibility for such prevention is placed solely on the individual (or his/her family). The policy responses that emerge from this viewpoint thus seek to promote "individual responsibility" by, for example, educating people about healthy living or imposing financial penalties (such as higher insurance premiums) for unhealthy choices. This individualist focus screens out policy responses that do not rely on individual action as the operative mechanism. In the context of obesity, for example, changes in social organization and the food supply have pushed a majority of the population towards less healthy eating and more sedentary lifestyles. Under the individualist/biomedical paradigm, however, the responsibility for reversing these society-wide (and even worldwide) trends is left up to each individual.

By contrast, the public health paradigm, which views health from the population perspective, conceptualizes prevention in a broader way that is sensitive to the social and environmental factors that influence health. The policy prescriptions that flow from such a view operate largely at the level of primary prevention and focus on changing a population's exposure to health risks. Although it may be somewhat counterintuitive, public health scholars have established that "[t]reating high-risk or diseased individuals does not have much of an impact on population health levels overall, but changing a risk factor across the whole population by just a small (and often clinically insig-

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[37] Charles Lewis, *The Role of Prevention, in* CHANGING THE U.S. HEALTHCARE SYSTEM 442-43 (Ronald M. Andersen et al. eds., 2d ed. 2001).

nificant) amount can have a great impact on the incidence of a disease or problem in the community."[38] Therefore, interventions aimed at the reducing health risks at the population level, such as seatbelt laws and smoke-free laws, often produce a much greater benefit to the population as a whole than high-tech medical interventions. Furthermore, they do so at much lower costs. Because these interventions operate at the population level, however, they are typically ignored or marginalized by the individualist/biomedical paradigm.

Applying the public health paradigm to policymaking would evade the "deep capture" that has constructed health in primarily dispositionalist terms. In the obesity context, for example,

> [E]ven if advertising is not "the" cause of the obesity epidemic, indeed even if it only plays a minor role in determining the probability that any one child will be obese, across the population of children exposed to it directly and indirectly (through the behavior of their peers), advertising may significantly increase the number of cases of obesity.[39]

Consequently, while acknowledging the importance of individuals taking responsibility for their own health, a public health focus would recognize that junk-food advertising geared towards children is an appropriate target of regulation because of the predictable, negative impact it has on health at the population level.

In sum, the individualist/biomedical paradigm leads to a constricted view of what prevention is and what public health measures should target, while a public health paradigm takes a more expansive view of prevention and accordingly brings a wider range of policy options into view. The authors of the Affordable Care Act likely believed that they had developed a comprehensive prevention agenda, but they did not recognize that they were constructing the term "prevention" in a limited way.[40] The prevention-oriented provisions of the Act, discussed in the following section, reflect the individualist/biomedical paradigm

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[38] FRAN BAUM, THE NEW PUBLIC HEALTH 14 (3d ed. 2008).

[39] PARMET, *supra* note 9, at 184.

[40] Alternatively, the authors of the Affordable Care Act may have recognized the limitations of their prevention-oriented provisions, but felt constrained by the current political climate to focus on policy approaches that emphasized "individual responsibility." *See, e.g.*, Dennis Raphael & Toba Bryant, *Public Health Concerns in Canada, the U.S., the U.K., and Sweden*, *in* STAYING ALIVE: CRITICAL PERSPECTIVES ON HEALTH, ILLNESS, AND HEALTH CARE 347, 364 (Dennis Raphael et al. eds., 2006) ("In Canada and the U.S., progressive concepts associated with health promotion and population health are inconsistent with nascent neo-liberal approaches to government that emphasize individualism, rather than communal approaches, to resource allocation.").

by focusing narrowly on clinical (secondary and tertiary) preventive services and measures to encourage "personal responsibility" for healthy choices. While these measures are not unimportant, they could be dramatically enhanced by incorporating the lessons of the public health field. Had the lawmakers applied a public health paradigm, they would have produced a very different set of policy responses that took into consideration the environmental factors that impact health at the population level.

II. THE PUBLIC HEALTH PROVISIONS OF THE AFFORDABLE CARE ACT

This section reviews the major provisions of the Affordable Care Act relating to preventive health. I have grouped these provisions into three major categories: information awareness campaigns, clinical preventive services, and workplace wellness initiatives. For each of these topics, I summarize the relevant provisions of the Act and then discuss the conception of prevention and public health that these provisions enact into law.

As will be readily apparent, the provisions of the Act clearly reflect the influence of the individualist/biomedical paradigm. Many provisions rely heavily on biomedical approaches to detecting and reducing disease, while others focus on a personal responsibility approach to reducing health risks. These individual provisions are in many cases well thought out and much needed, but because they are rooted in the individualist/biomedical paradigm, they do not contain population-based approaches that could address health disparities and effectively confront the social and environmental factors fueling our most severe public health challenges. Consequently, the Affordable Care Act's public health provisions represent an unfortunate lost opportunity to shift public health policy-making in new and more promising directions.

A. Information Awareness Campaigns

Even those skeptical of any government interference in personal affairs can recognize the need for government to help alleviate the "information asymmetries" that make it difficult for people to make informed decisions about their health.[41] The Affordable Care Act con-

[41] *See* LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 339 (rev. and expanded 2d ed. 2008) ("Certainly, failure to inform citizens of scientific information relevant to their health and safety would be objectionable. Most people want government to educate the public about healthy lifestyles, recognizing that existing information sources may be insufficient, unreliable, or confusing.").

tains two very different provisions that seek to provide consumers with the information needed to make healthy choices. The first provides funding for a national public health education campaign, and the second requires chain restaurants to inform customers of the number of calories in their menu items.

1. Public Health Education Fund

Title IV of the Affordable Care Act provides up to $500 million for the creation of a "national public-private partnership for a prevention and health promotion outreach and education campaign . . . ."[42] The educational campaign described—which will include media campaigns, a website, and distribution of information through health care provides—is squarely focused on altering individual behavior. The campaign is intended to "promote[] the use of preventive services" and to "encourage[] healthy behaviors linked to the prevention of chronic diseases."[43] In addition, the campaign's website will include tools that allow individuals to assess their own health and create a "personalized prevention plan."[44]

The operating principle behind this provision appears to be that if consumers are provided with more information about healthy behaviors, they will make healthier choices. As such, this provision reflects the individualist/biomedical paradigm that assigns individuals the primary responsibility for protecting and promoting their own health (helped, in this case, by friendly reminders from the government).

The public health media campaign that will be funded by this section has not yet been designed, but in general, the historical record suggests that unless such campaigns are combined with other public health interventions, they "are rarely effective in modifying complex behaviors such as dieting and exercise."[45] As Fran Baum writes:

> Early models of behavior change were based on the assumption of a relatively stable link between knowledge, attitude and behavior—if people were given relevant information (i.e., too much fat is bad for your health) from a credible source

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[42] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4004, 124 Stat. 119, 544 (2010) (codified as amended at 42 U.S.C. § 300u-12 (2010)).

[43] *Id.*

[44] § 4004, 124 Stat. at 545. A separate section creates a "pilot program to test the impact of providing at-risk populations who utilize community health centers . . . an individualized wellness plan that is designed to reduce risk factors for preventable conditions . . . ." § 4206, 124 Stat. at 576.

[45] Kelli K. Garcia, *The Fat Fight: The Risks and Consequences of the Federal Government's Failing Public Health Campaign*, 112 PENN. ST. L. REV. 529, 538 (2007).

> (nutritionist) they would change their attitudes towards their diet and, in turn, their behavior (reducing fat intake). Experience showed that this was not correct . . .[46]

Rather, "[w]hile health education programs may be able to modify our general attitudes towards weight loss, healthy eating, and exercise, they cannot modify the vast majority of factors that influence our eating and exercise habits."[47] As a result, past information awareness campaigns—even hard-hitting ones such as the famous "This is Your Brain on Drugs" campaign—have not had a strong track record in modifying behavior.[48]

Furthermore, to the extent that individuals are able to change their behaviors and improve their health status, this is likely because they are relatively good health to begin with and have the material well-being to be able to prioritize health improvement. Accordingly, information awareness campaigns, even if effective for some people, will likely increase health disparities at the population level. Meanwhile, those who—for a variety of potential reasons—are unable to improve their health status, may be harmed by the dispositionalist framing of the public health messages. As Kelli Garcia writes in the context of obesity: "Health education programs that treat weight as simply being a matter of self-control encourage beliefs that the obese and overweight lack will-power. These beliefs, in turn, contribute to discrimination against the overweight and obese by feeding already existing stereotypes that the obese and overweight are lazy."[49]

More fundamentally, what is problematic about these information awareness campaigns is not their content, but rather the fact that they are used as a substitute for, instead of a complement to, more robust public health measures that would seek to uncover and address the underlying causes of poor health. No attempt is made to address the environmental risk factors threatening health, because under the individualist/biomedical paradigm, "[p]olicies that seek to change environments will not be perceived as effective because individual behavior is seen as the overriding causal factor."[50]

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[46] FRAN BAUM, THE NEW PUBLIC HEALTH 323 (2d ed. 2002).

[47] Garcia, *supra* note 45, at 539.

[48] *Id.* at 568 ("[H]ealth information campaigns, such as the now infamous, 'This is your Brain on Drugs,' campaign and the school DARE program have been largely ineffective.").

[49] *Id.* at 564.

[50] BAUM, *supra* note 46, at 338.

2. Menu Labeling Requirement

Another information-oriented provision included in the Act is the requirement that chain restaurants with twenty or more locations must post the number of calories contained in each standard menu item on menu boards.[51] This requirement will take effect in 2011. Although this provision is significantly different from a national health promotion campaign, it is simply another way for the government to provide information that consumers may find relevant and necessary to making healthy decisions about food consumption. Following the lead of New York City, which required calorie counts to be posted in chain restaurants starting in 2008, states and communities around the county were in the process of adopting similar laws.[52] Facing the potential of a "cacophony of different laws" in different jurisdictions, the National Restaurant Association reversed its opposition to a national menu labeling law, "thereby paving the way for a national law that supersedes local and state laws."[53]

The goal of this menu labeling requirement is likely multifold. Primarily, its purpose is to encourage more responsible choices by individual consumers. In this respect, it is likely that the effect of this provision will be limited for similar reasons. The first study to analyze the impact of New York City's law found that "although nearly 28% of [low-income] New York customers said they noticed and were influenced by calorie labeling, this group purchased about the same number of calories as [those who did not notice the labeling]."[54] This confirmed the findings of another recent laboratory study which found that "providing calorie information at the point-of-purchase on a fast food restaurant menu had little effect on food selection and consumption" among a group of people who ate fast food at least once a

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[51] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4205, 124 Stat. 119, 573 (2010) (codified as amended at 21 U.S.C. § 343(q)(5)(A) (2010)). The calorie counts must be posed in a "clear and conspicuous manner," and the menu boards must include a prominent posting of the "suggested daily caloric intake, as specified by the Secretary [of Health and Human Services]." *Id.*

[52] Marion Nestle, *Health Care Reform in Action—Calorie Labeling Goes National*, 362 NEW ENG. J. MED. 2343, 2344 (2010).

[53] *Id.*

[54] *Id.* (discussing Brian Elbel et al., *Calorie Labeling and Food Choices: A First Look at the Effects on Low-Income People in New York City*, 28 HEALTH AFF. W1037, W1110 (2009)). A follow-up study analyzing the impact of New York City's calorie labeling on adolescents found that the study participants "did not respond in any measurable way to the presence of labels within our study time period." B. Elbel et al., *Child and Adolescent Fast-Food Choice and the Influence of Calorie Labeling: A Natural Experiment*, 35 INT'L J. OBESITY 493, 493 (2011), *available at* http://www.nature.com/ijo/journal/vaop/ncurrent/full/ijo20114a.html.

week.[55] As with the information awareness campaigns discussed above, the provision of more information to consumers is generally not powerful enough to counteract the wide range of factors that influence choices about food. As Lisa Harnack and Simone French summarize:

> [R]esults across studies uniformly indicate that calorie labeling may have a beneficial effect on food choices made away from home. However, the effect is likely limited in magnitude. This limited effect may reflect the low level of importance many consumers place on nutrition when eating out. It may also reflect the multi-level nature of food choices, with influences occurring at the individual level prior to the restaurant, and other strong environmental influences at the restaurant, such as food choices, prices and other promotional activities at the point-of-purchase, and the influence of other people at the point of choice. Multiple levels of influence may need to be targeted in tandem, including consumer attitudes about calories when eating out, in order for calorie labeling to have a more substantial influence on restaurant food choices.[56]

However, another goal of the calorie posting may be to pressure restaurants to reduce the number of calories in their food. "Menu labeling, in other words, has the potential to not only change what diners choose, but what they're offered."[57] Thus, it is less clear that the menu labeling requirement is purely a reflection of the individualist/biomedical paradigm. By seeking to change the food environment, the law also embodies the public health paradigm in that it has the potential to change the food environment that consumers encounter when they enter restaurants. New York City's Health Department suggests that "calorie reductions [in menu items] of about 10% have

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[55] Lisa J. Harnack et al., *Effects of Calorie Labeling and Value Size Pricing on Fast Food Meal Choices: Results from an Experimental Trial*, 5 INT'L J. BEHAV. NUTRITION & PHYSICAL ACTIVITY 63, 64-65 (2008).

[56] Lisa J. Harnack & Simone A. French, *Effect of Point-of-Purchase Calorie Labeling on Restaurant and Cafeteria Food Choices: A Review of the Literature*, 5 INT'L J. BEHAV. NUTRITION & PHYSICAL ACTIVITY 51, 53 (2008).

[57] Ezra Klein, *The Promise of Menu Labeling*, WASH. POST (July 27, 2009, 1:35 PM), http://voices.washingtonpost.com/ezra-klein/2009/07/the_promise_of_menu_labeling.html.

been common" since the city's menu labeling law went into effect, although the evidence supporting this assertion is somewhat mixed.[58]

B. Increasing Access to Clinical Preventive Services

Although the pieces of the Affordable Care Act relating to clinical preventive services are located outside of Title IV, they were clearly intended to be a central piece of the law's prevention-oriented efforts. Title I of the Affordable Care Act, which addresses access to health insurance, includes a requirement for all private health insurance carriers to provide full coverage for clinical preventive services recommended by the United States Preventive Services Task Force (USPSTF), without any cost-sharing by the enrollees.[59] In other words, all recommended tests and screenings will be free for everyone carrying private insurance, at least in the sense that there will be no deductable and no co-payments. (Of course the cost of these services will be factored into premium rates, so in that sense the services will not be free.) Pursuant to this provision, pap smears, colonoscopies, cholesterol tests, HIV tests, and a number of other tests will now be fully covered by insurance, at least for individuals in the age ranges for which testing is recommended.[60] The law also requires full coverage of certain immunizations recommended by the Centers for Disease Control and Prevention (CDC), as well as child health services

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[58] Nestle, *supra* note 52, at 2345 (noting that although some restaurants had reduced the number of calories in particular menu items, the number of calories in other items had increased since the labeling requirement went into effect).

[59] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1001, 124 Stat. 119, 131 (codified as amended at 42 U.S.C. 300gg-13 (2010)). The USPSTF is a panel of private-sector experts convened by the Agency for Healthcare Research and Quality (AHRQ), which is tasked with "review[ing] the scientific evidence related to the effectiveness, appropriateness, and cost-effectiveness of clinical preventive services for the purpose of developing recommendations for the health care community[.]" 42 U.S.C. § 299b-4 (2006).

[60] The USPSTF, however, is somewhat conservative in deciding what tests to recommend. In the past, at least, "[t]he USPSTF has frequently stood alone in its recommendations, presenting more conservative guidelines than those of the American Cancer Society and various specialty medical societies." Bruce Jancin, *Pending USPSTF Report Confronts Evidence Gaps*, OB GYN NEWS, Nov. 1, 2000, http://findarticles.com/p/articles/mi_m0CYD/is_21_35/ai_67316710/. The new law, however, does give it "new freedom to consider less definitive evidence previously out of bounds," including the opinion of the American Cancer Society and other such specialty groups. Bill Malone, *Healthcare Reform Arrives: How Will Labs Fare in the New Era?*, CLINICAL LABORATORY NEWS, June 2010, at 3, *available at* http://aacc.org/publications/cln/2010/june/Documents/CLNJune2010.pdf; *see* § 4003, 124 Stat. at 542 (indicating the USPSTF "shall consider clinical preventive best practice recommendations from . . . specialty medical associations, patient groups, and scientific societies.").

recommended by the Health Resources and Services Administration (HRSA).[61]

Title IV of the Act extends similar benefits—including full clinical preventive services recommended by the USPSTF—to Medicare recipients,[62] and it makes additional funding available to states if they agree to provide Medicaid recipients with full coverage of these preventive services.[63] Other provisions of Title IV entitle Medicare recipients to an "annual wellness visit" with their physicians (which will not require any co-pay)[64] and require Medicaid to cover tobacco cessation treatment for pregnant women.[65]

For the most part, these provisions of the Affordable Care Act focus on increasing access to secondary preventive services. (A notable exception is the provision dealing with childhood vaccinations, an extremely important primary prevention intervention.) Even under an approach focused on primary prevention, testing and screening is sometimes necessary. Not all disease can be prevented, and sometimes early detection is the best option.

What these provisions demonstrate, however, is a focus on clinical testing to the exclusion of other population-based approaches. Policymakers operating under a public health paradigm would recommend clinical preventive services for appropriate populations, but would also search for non-clinical, primary prevention programs that seek to reduce the incidence of disease and injury. In fact, the USPSTF's recommendations also include a variety of policy and programmatic interventions that reflect a broader understanding of pre-

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[61] § 1001, 124 Stat. at 131 (codified as amended at 42 U.S.C. 300gg-13 (2010)). Section 2713(a)(4) requires that women's health services recommended for coverage by HRSA in the future must be fully covered as well. In addition, the Secretary of Health and Human Services must "define the minimum benefits for insurance sold through an exchange," and could require the coverage of additional preventive services through this mechanism. STAFF OF THE WASHINGTON POST, LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH-CARE LAW AND WHAT IT MEANS FOR ALL OF US 145, 148 (2010) (noting that "[t]he standards for minimum coverage for exchange-based insurance could become one of the next battlegrounds, giving commercial interests and patient advocacy groups fresh opportunities to try to shape coverage").

[62] § 4104, 124 Stat. at 557.

[63] § 4106, 124 Stat. at 559-60 (to be codified as amended at 42 U.S.C. § 1396d(b)). The amendment to 42 U.S.C. § 1396d(b) does not take effect until 2013. *Id.*

[64] § 4103, 124 Stat. at 553 (codified as amended at 42 U.S.C. §§ 1395x, 1395*l*(a)(1) (2010)).

[65] § 4107, 124 Stat. at 560 (codified as amended at 42 U.S.C. § 1396d (2010)).

ventive health. For example, the USPSTF has previously recommended the following:

- Comprehensive early childhood development programs for low-income children, "on the basis of strong evidence that they improve intermediate cognitive and social outcomes, which in some cases are markers of improved long-term health outcomes";[66]

- Rental assistance programs to subsidize low-income housing, "on the basis of sufficient evidence of effectiveness in reducing exposure to crimes . . . and decreasing neighborhood social disorder";[67]

- Smoke-free laws that prohibit smoking in public places, because such laws not only reduce exposure to secondhand smoke but reduce cigarette consumption as well;[68] and

- Programs that create places where the public can exercise or that otherwise expand access to fitness equipment.[69]

These recommendations recognize that creating conditions in which people can live healthy lives is just as important as quickly detecting and treating diseases when they occur. In addition, they may be less costly, because they seek to prevent disease from occurring instead of intervening (as clinical tests do) when the best possible outcome is to limit the progression of a disease, often through the use of costly pharmaceuticals or medical procedures. However, these recommendations do not comport with the way that the individualist/biomedical paradigm conceptualizes prevention, and they were not included in the Affordable Care Act.[70]

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[66] TASK FORCE ON COMMUNITY PREVENTIVE SERVICES, THE GUIDE TO COMMUNITY PREVENTIVE SERVICES 122 (Stephanie Zaza et al. eds., 2005).

[67] *Id.* at 125.

[68] *Id.* at 50-51.

[69] *Id.* at 100.

[70] Additionally, the co-pays that the Act will eliminate were only one of many barriers resulting in the underutilization of screening and testing services. Other barriers to care may include "cultural factors, distance, lack of transport," "inability to take time off of work," as well as "inadequate service quality (including lack of availability of medication equipment and personnel), and inappropriate hours of operation [by health care providers]." Fran E. Baum et al., *Changes Not for the Fainthearted: Reorienting Health Care Systems Towards Health Equity Through Action on the Social Determinants of Health*, 99 AM. J. PUB. HEALTH 1967, 1970 (2009) (internal parenthetical omitted).

In addition, expanding the use of testing and screening services is not always an unequivocal good. A product of the biomedical perspective is the assumption that the use of more (and more high tech) testing is always better medicine. As one doctor puts it, "People don't trust their physicians and assume they aren't doing a good job if they don't order more tests."[71] The usefulness of any given test depends, however, on both its sensitivity (the ability to detect the presence of the condition) and its specificity (accuracy in producing a positive test *only* for those who actually have the condition).[72] A test that is not sensitive enough will produce false negatives, giving a false assurance of health to those who are tested, while a test that is not specific enough will produce false positives which may lead to expensive and invasive procedures being performed on people who do not need them.

Recognition that a test lacking specificity may cause more harm than good led to the USPSTF's controversial recommendation in November 2009 against regular, biennial mammographies for women under the age of fifty. (The USPSTF had previously recommended a mammography every one or two years for all women over the age of forty; it now recommends a biennial mammograms for women between the ages of forty-nine and seventy-four.) The USPSTF "concluded that one cancer death is prevented for every 1,904 women age 40 to 49 who are screened for 10 years,"[73] but "[t]he false-positive rate for mammography annually over 10 examination was found to be as high as 56% for women aged 40 to 49 years," resulting in "high rates of additional testing and biopsies, overdiagnosis, . . . an increase in breast-cancer specific distress and in increase in the self-perception of breast cancer risks after false-positive results."[74] Reviewing this evidence, the USPSTF concluded that for most women under the age of fifty, the potential benefit of mammography screening was limited and was offset by the risks, expenses, and trauma that could accompany a false positive result.[75] Rather than recommend routine screening,

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[71] Robert Langreth, *Good Medicine: When to Say No to Your Doctor*, FORBES, Nov. 30, 2009, at 64, 66 (quoting Dr. Richard Deyo).

[72] *See* GOSTIN, *supra* note 41, at 396-97.

[73] Gina Kolata, *New Guidelines Suggest Cutback in Mammograms*, N.Y. TIMES, Nov. 17, 2009, at A1.

[74] Jason P. Block, *Compelling Evidence Leads to Change in USPSTF Recommendations on Breast Cancer Screening*, 17 J. CLINICAL OUTCOMES MGMT. 52, 53 (2010) (reviewing and summarizing the USPSTF recommendations).

[75] As one commentator put it: "You need to screen 1,900 women in their 40s for 10 years in order to prevent one death from breast cancer, and in the process you will have generated more than 1,000 false-positive screens and all the overtreatment

the USPSTF suggested that each woman in her forties "should talk to [her] doctor and make an informed decision about whether mammography is right for [her] based on [her] family history, general health, and personal values."[76]

The USPSTF did not propose that mammograms—which are have shortcomings in both sensitivity and specificity[77]—should be prohibited or limited; rather, it simply suggested their overuse was not without costs. As explained by one medical expert (whose analysis applies more broadly to clinical preventive services):

> Everyone originally came to the screening issue thinking it only produced benefits . . . But now it's more broadly recognized that it also brings harms. We need to weigh those . . . The idea that the best way to stay healthy is to look as hard as you can for everything you can is actually a recipe for doing a lot of harm. Screening is about looking for something in the well. It's really hard to make a well person better. But it's really easy to make them worse.[78]

The general reaction to the USPSTF's recommendations, however, ranged from confusion to intense anger. The Obama administration quickly distanced itself from the panel's recommendations (it suggested that the USPSTF members were Bush Administration appointees),[79] and polls suggested that most women would simply ignore the recommendation. According to a Gallop poll, "a whopping 84 percent of those between age 35 and 49 intend to reject the advice entirely."[80] With the biomedical perspective so well engrained, "many patients—and organizations of doctors and disease specialists—[found] them-

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they entail. This doesn't make sense." Robert Aronowitz, *Addicted to Mammograms*, N.Y. TIMES, Nov. 20, 2009, at A35.

[76] *Screening for Breast Cancer*, U.S. PREVENTATIVE SERVS. TASK FORCE, http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm (last visited Feb. 2, 2011).

[77] Anne M. Murphy, *Mammography Screening for Breast Cancer: A View from 2 Worlds*, 303 JAMA 166, 166 (2010).

[78] Rob Stein, *Fierce Debate Raging Over New Cancer Test Guidelines*, WASH. POST, Nov. 22, 2009, at A7 (quoting H. Gilbert Welch, Professor of Medicine at the Dartmouth College Institute for Health Policy and Clinical Practice) (internal quotation marks omitted).

[79] Gina Kolata, *Mammogram Debate Took Group by Surprise*, N.Y. TIMES, Nov. 20, 2009, at A16.

[80] Tracy Clark-Flory, *Mammogram advice? Meh*, SALON.COM (Nov. 24, 2009), http://www.salon.com/life/broadsheet/feature/2009/11/24/purity/index.html. The poll also found that "40 percent of women believe that a 40-year-old woman has a 20 to 50 percent chance of developing cancer over the next decade, when her actual risk is only 1.4 percent." *Id.*

selves unready to accept the counterintuitive notion that more testing can be bad for your health."[81]

The political system quickly responded to public pressure, increasing access to clinical preventive testing despite questions about whether it was medically warranted:

> [I]n response to the USPSTF recommendation, the US Senate passed an amendment to require insurers to provide free preventive services for women including screenings not only for breast cancer, but also for ovarian, lung, and other cancers. However, even the American Cancer Society does not recommend either ovarian or lung cancer screening because screening tests for both diseases lack evidence of benefit and can cause substantial harm.[82]

The final version of the legislation did not include free coverage of ovarian and cancer screening, but it did create an exception that specified that in the case of breast cancer screening, the prior version of the USPSTF's recommendations—recommending regular mammograms for all women in their forties—would govern.[83]

The controversy over the USPSTF's mammography guidelines—and the Affordable Care Act's rejection of them—suggests that the "logic of the early detection model," a manifestation of the biomedical perspective, is deeply engrained within the American psyche.[84] As a nation, we have come to rely on the belief that early detection and treatment of disease is the primary and most effective way to preserve health, and this is clearly the framework that animates the clinical preventive services provisions of the Affordable Care Act.

C. Workplace Wellness Programs

In addition to information campaigns and expanded access to clinical preventive services, the third element of the Affordable Care Act that has been touted as a public health initiative is the expansion of

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[81] Kevin Sack, *Science and Sentiment Collide Over Cutting Cancer Tests*, INT'L HERALD TRIB., Nov. 21-22, 2009, at 4.

[82] Steven Woloshin & Lisa M. Schwartz, *The Benefits and Harms of Mammography Screening: Understanding the Trade-offs*, 303 JAMA 164, 165 (2010).

[83] Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1001, 124 Stat. 119, 131-32 (codified as amended at 42 U.S.C. § 300gg-13 (2010)) ("[F]or the purposes of this Act . . . the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.").

[84] Aronowitz, *supra* note 75.

workplace wellness programs. These programs have been promoted as a way to both improve employee health and reduce health care costs for businesses. "Workplace wellness programs" encompass a wide range of initiatives utilized by employers to improve the health of their employees. Such programs may include health-promoting facilities or programs at the worksite (e.g., a company gym, healthy items in the company cafeteria, or worksite smoking cessation classes), support for off-site activities (e.g., discounts for gym memberships or weight loss programs), or clinical preventive services (e.g., free health assessments or cancer screenings).[85] These programs may be combined with incentives for either participating in these activities or improving one's health.

The Affordable Care Act provides up to $200 million in grant funding to private businesses to expand workplace wellness programs,[86] but the most significant workplace wellness provision in the Act is likely the one that modifies the nondiscrimination rules included in the Health Insurance Portability and Accountability Act (HIPAA). HIPAA's nondiscrimination rules require group health plans to charge the same premium to all subscribers, regardless of their health status. However, HIPAA contains a "wellness program exception" which allows employers to charge higher premiums to some employees, as long as the premium differentials are imposed as part of a workplace wellness program. Under the rules in place prior to the enactment of the Affordable Care Act, the reward offered for participation in a wellness plan could not exceed 20 percent of the cost of the employee's premium. For example, an employer could offer a health insurance discount to employees who quit smoking, but the discount could not exceed 20 percent of the cost of an individual's coverage.[87]

Title IV of the Affordable Care Act modifies the HIPAA wellness program exception, providing that the a premium discounts offered as part of a workplace wellness program now cannot exceed 30 percent of the cost of the employee's insurance premium.[88] In addition, the

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[85] *Guide to Community Preventative Services*, THE CMTY. GUIDE BRANCH, EPIDEMIOLOGY ANALYSIS PROGRAM OFFICE, OFFICE OF SURVEILLANCE, EPIDEMIOLOGY, AND LAB. SERV., CTRS. FOR DISEASE CONTROL AND PREVENTION, http://www.thecommunityguide.org/worksite/index.html (last updated Sept. 21, 2010).

[86] § 10408, 124 Stat. at 977-78.

[87] Under HIPAA, there would also have to be a different way of obtaining the discount for anyone for whom it was medically inadvisable or "unreasonably difficult" to quit smoking. 45 C.F.R. § 146.121(f) (2009).

[88] § 1201, 124 Stat. at 157 (codified as amended at 42 U.S.C. § 300gg-4 (2010)).

law provides that "[t]the Secretaries of Labor, Health and Human Services, and the Treasury may increase the reward available under this [section] to 50 percent of the cost of coverage if the Secretaries determine that such an increase is appropriate."[89] As the law specifies that the insurance premium is calculated by adding the employee's and the employer's contributions, this provision provides employers with substantial additional leverage to encourage employees to participate in workplace wellness plans.[90] Currently, the average cost of an employer-sponsored health care plan is $4,824 per person, so the law would allow rewards or penalties associated with wellness plans to reach as high as $1,447 per person (30%), or as high as $2,412 per person (50%) if the cap is adjusted.[91]

Since most people spend the majority of their day at the workplace, increasing worksite access to healthy foods, exercise opportunities, and healthcare services is unquestionably a necessary step towards improving the population's health. Workplace wellness programs embody the public health paradigm to the extent that they seek to create a healthier work environment for all employees. As it stands now, however, "well-educated, highly-paid workers are more likely to have access to wellness programs, compared to less formally educated, low-income workers."[92] Because obesity, tobacco use, and other health risk factors are much more prevalent among the lower socioeconomic strata, a focus on workplace wellness programs—in the absence of a concerned effort to make such opportunities available to all workers—is likely to exacerbate already-existing health disparities.[93] Accordingly, expanding access to workplace wellness opportunities—as the $200 million in grant funding is intended to do—is sensible.

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[89] § 1201, 124 Stat. at 158.

[90] *Id.* Section 1201 will also create a ten-state demonstration project in which similar incentives can be employed in the individual health insurance market. § 1202, 124 Stat. at 159.

[91] LANDMARK, *supra* note 61, at 151.

[92] *See* Lydell C. Bridgeford, *Study Links Class, Income to Access to Wellness Programs*, EMPLOYEE BENEFIT NEWS, Aug. 2009, at 1 (citing a Rutgers University study finding that employees with annual incomes of $70,000 or higher are more than twice as likely as those with annual incomes of $35,000 or less to have access to wellness benefits at work).

[93] Wendy Mariner notes that workplace wellness programs may be not be an ideal vehicle for extending health-related opportunities to the public, because the goal of such programs is to reduce employer costs, at least as much (if not more so) than it is to improve employee health. As such, a focus on workplace wellness programs "discounts improved health and wellbeing as valuable for their own sake" and "may discourage independent initiatives to promote health unless they prove financially rewarding." Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Care Reform*, 14 CONN. INS. L.J. 199, 222 (2008).

However, the key legal change included in the Act, which allows employers to increase the financial pressure on employees to improve their health, embodies an understanding of prevention rooted in the individualist/biomedical paradigm. The assumption underlying this provision seems to be that the reason people have not improved their health statutes is that they have not had a sufficient incentive to do so. Allowing for 30 percent—and potentially 50 percent—higher premiums for those who do not meet health targets threatens to exacerbate already-existing disparities *within* workplaces. As Wendy Mariner writes, "the people most likely to be subject to wellness program requirements may be those who need insurance the most and can least afford higher costs."[94] In fact, the American Heart Association, the American Cancer Society, and the American Diabetes Association released a joint statement opposing this provision, arguing that "[p]enalizing workers who do not meet certain health targets by passing on the cost of higher health care premiums" threatened to undermine the Affordable Care Act's central purpose of making affordable health insurance available to all, regardless of health status.[95]

D. Other Provisions, Including The Prevention and Public Health Fund

The Affordable Care Act also contained many other provisions—primarily in Section IV—which were classified as public health provisions. Most of these provisions, too numerous to list here, create a hodge-podge of grant programs, demonstration projects, and research initiatives. Given the sometimes ugly, "sausage making" process that produced the Affordable Care Act, it is perhaps not surprising that the public health provisions do not reflect any coherent, sustained vision,

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[94] *Id.* at 225.

[95] *National Patient Groups Oppose Allowing Employers to Charge Less Health Workers For More Health Care*, AM. CANCER SOC'Y CANCER ACTION NETWORK (Jan. 7, 2010), http://www.acscan.org/mediacenter/view/id/252/. Sue Nelson of the American Heart Association suggested that with this provision, "[t]here could be an inclination to say, 'Let's raise everyone's costs and just lower them for the 15 percent that can meet the standards[.]'" Erica Werner, *Advocacy Groups Raise Concerns on Health Bill*, BOSTON.COM (Jan. 7, 2010), http://www.boston.com/business/healthcare/articles/2010/01/07/ap_sources_obama_backs_high_end_health_plan_tax/. The concern may be overstated, as the penalty cannot be applied to people for whom it is "unreasonably difficult due to a medical condition, or medically inadvisable," to satisfy the standard. § 1201, 124 Stat. at 154-55 (codified as amended at 42 U.S.C. § 300gg-4 (2010)).

and many of them look like sweeteners intended to win over particular constituencies.[96]

One additional provision of the law merits further discussion here. Title IV creates a "Prevention and Public Health Fund" which, if fully funded—and that's a very big *if*—will provide $15 billion to spend on public health initiatives over the next ten years.[97] The use of this fund, which will be managed by the Office of the Secretary of the Department of Health and Human Services, is remarkably unconstrained. The only guidance is that money is to be spent on "programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research and health screenings, such as the Community Transformation grant program, the Education and Outreach Campaign for Preventive Benefits, and immunization programs."[98]

In some sense, $15 billion over ten years is only a modest amount to invest in public health and prevention.[99] That sum represents only 1.5 percent of the Act's total costs, and it is less than half the amount

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[96] One section that may have a significant public health benefit is a 10 percent tax on the cost of some artificial tanning services. § 10907, 124 Stat. at 1020 (codified as amended at 26 U.S.C § 5000B (2010)). The central purpose of this provision was undoubtedly to raise revenue to pay for the Act, the Act may also have a public health impact by discouraging the use of cancer-causing tanning beds. The loopholes in the tax—it does not apply to tanning salons located within fitness facilities, for example—make its impact more uncertain.

[97] § 4002, 124 Stat. at 541 (to be codified at 42 U.S.C. § 300u-11 (2010)). The Act also calls for $2 billion in funding for each subsequent year (though that may be diverted to other purposes). *Id.* Earlier drafts of both the Senate and House legislation included considerably larger "investment funds" to support public health efforts. Sen. Mike Enzi (R-WY) criticized the provisions in the draft Senate bill as "an $80 slush fund for additional pork-barrel projects," and the proposed amount was later substantially reduced. Kristina Sherry, *Billions to Fight Obesity at Issue; Health Care Measure's Wellness Provisions Stirs Debate on Savings*, BALTIMORE SUN, Aug. 3, 2009, at A1. Even now, full funding of the Prevention and Public Health Fund is by no means assured. In September, the Senate narrowly rejected an amendment introduced by Sen. Mike Johanns (R-NE) that would have diverted $11 billion from the fund. Alex Daniels, *Senators Reject Bids to Change Health Law; Firms Must Still Do IRS Reports*, ARK. DEMOCRAT-GAZETTE, Sept. 15, 2010, at 1A. As of March 2011, Congress was considering using $750 million from the fund to offset cuts to the CDC's budget.

[98] § 4002, 124 Stat. at 541 (to be codified at 42 U.S.C. § 300u-11 (2010)).

[99] As one commentator notes, "Certainly with the size of the cuts happening at the state and local level [$15 billion] probably doesn't even cover the losses that have already occurred, much less strengthen a public health system that is being asked to do more than ever by the American people . . . ." James S. Marks, *Friendly Fire in Prevention?*, HUFFINGTON POST (July 23, 2010, 3:45 PM), http://www.huffingtonpost.com/james-s-marks/friendly-fire-in-preventi_b_657549.html.

that the National Institutes of Health (NIH) spends on biomedical research every year.[100] Nonetheless, $15 billion represents a tremendous boost in public health funding. The CDC's budget, which represents much of the spending on public health at the federal level, is approximately $10 billion annually, and most of its funding is spent on childhood vaccinations and emergency preparedness.[101] Only a small portion of the CDC's budget is spent on health promotion and chronic disease prevention. Thus, the $15 billion, if applied for those purposes, would represent a huge increase in funding.[102]

The Prevention and Public Health Fund's impact will depend, of course, on how it is spent. The initial announcement by the Obama Administration demonstrated priority-setting wholly in line with the individualist/biomedical perspective. The Administration's first statement about the use of the trust fund was to announce that $250 million—half of the money authorized for the Act's first year—would be spent on training programs for new doctors, nurses, and other health care workers.[103] Most of the money will go toward creating 500 new residency positions for primary care physicians. While expanding the primary care workforce is a laudable objective (and much needed after the Affordable Care Act's broad expansion of insurance coverage), spending the money in this way frames prevention and public health in purely biomedical terms. At the press conference announcing the spending, Secretary Sebelius explained that the spending was an appropriate use of the trust fund because "[p]rimary care providers are on the front line in helping Americans stay healthy by preventing disease, treating illness, and helping to manage chronic conditions."[104]

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[100] Indeed, the American Recovery and Reinvestment Act provided the NIH with $10 billion to spend on biomedical research in only two years. Bloomberg News, *NIH Says Stimulus Funds Add Jobs, Boost Research*, BOS. GLOBE, Jan. 2, 2010, at Bus. 5.

[101] *See* U.S. DEP'T OF HEALTH AND HUMAN SERVICES, CENTERS FOR DISEASE CONTROL AND PREVENTION JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES (2009), http://www.cdc.gov/fmo/topic/Budget%20Information/appropriations_budget_form_pdf/FY09_CDC_CJ_Final.pdf.

[102] Diversion of the fund to other purposes remains a serious threat. In September, the Senate considered an amendment to the Small Business Jobs and Credit Act introduced by Sen. Mike Johanns (R-NE) that would have defunded the Prevention and Public Health Fund in order to reduce reporting requirements for businesses. The Amendment was narrowly defeated on a 46-52 procedural vote. Alex Daniels, *Senators Reject Bids to Change Health Law; Firms Must Still Do IRS Reports*, ARK. DEMOCRAT-GAZETTE, Sept. 15, 2010, at 1A..

[103] News Release, U.S. Dep't of Health and Human Servs., Sebelius Announces New $250 Million Investment to Strengthen Primary Health Care Workforce (June 16, 2010), http://www.hhs.gov/news/press/2010pres/06/20100616a.html.

[104] *Id.*

Such spending will marginally expand the number of primary care providers available, but the public health impact—i.e., the impact on health at the population level—is questionable.[105]

The Administration later announced that the remainder of the $500 million allocation for the first year would be spent on "investments to support prevention activities and develop the nation's public health infrastructure."[106] This new spending will consist mostly of grants to state and local government for a variety of activities including obesity prevention and tobacco cessation efforts.[107] Some of these programs will likely seek to promote policy changes addressing environmental determinants of disease. Dr. Thomas Frieden, the director of the CDC, is deeply committed to a public health paradigm of prevention.[108] To the extent that the CDC is tasked with distributing grants from the Prevention and Public Health Fund, his viewpoint may well be influential. Ultimately, the Fund presents administration officials with a tremendous opportunity to attack the leading causes of chronic disease, but it is yet to be seen which paradigm will influence their interpretation of their mandate.

III. CONCLUSION AND FUTURE DIRECTIONS

Past health care reform efforts, including the Clinton Administration's proposal in 1993, completely overlooked public health and prevention. For this reason, it is not surprising that many public health

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[105] Even some of the Title IV's authors were disappointed that the money was allocated in a way so tangentially connected to preventive health. Meghan McCarthy, *Key Dems Criticize HHS Reshuffling of Public Health Fund*, CONGRESS DAILY (June 17, 2010), http://www.govexec.com/story_page_pf.cfm?articleid=45513. The Administration claimed that this was a one-time allocation and that no additional money from the fund would go towards training health care providers. However, because the medical community has a stronger lobbying presence than public health advocates, it seems likely that there will be continued pressure to spend at least some of the Prevention and Public Health Fund money on primary care.

[106] News Release, U.S. Dep't of Health and Human Services, Sebelius Announces New $250 Million Investment to Lay Foundation for Prevention and Public Health (June 18, 2010), http://www.hhs.gov/news/press/2010pres/06/20100618g.html.

[107] A large portion of this money will be spent on "shovel-ready," stimulus-style grants. These types of grants have been criticized for giving an advantage to communities that already have a strong public health infrastructure in place (and thus deepening existing disparities). Julie Appleby, *Groups Vie for a Piece of Health Law's $15 Billion Prevention Fund*, KAISER HEALTH NEWS (May 7, 2010), http://www.kaiserhealthnews.org/Stories/2010/May/08/prevention-money-fight-health-reform-law.aspx.

[108] *See generally* Thomas R. Frieden, *A Framework for Public Health Action: The Health Impact Pyramid*, 100 AM. J. PUB. HEALTH 590 (2010) (advocating preventative interventions that address social determinants of health).

advocates were enthusiastic about the Affordable Care Act's prevention-oriented provisions. It is important, however, to take a step back and consider how the Act conceptualizes "public health" and "prevention." As discussed above, the Act's prevention-oriented provisions operationalize an understanding of prevention and public health derived from the individualist/biomedical paradigm. This narrow understanding of preventive health sees better individual decision-making and improvements in medical technology (and the availability of medical technology) as the keys to improving health. Ignored are the lessons of public health professionals that view the most effective interventions as operating at the primary prevention level, focusing on environmental risk factors that contribute to disease. In short, while the Affordable Care Act was a step forward for public health—and a giant leap towards universal insurance coverage—an opportunity to adopt a broader prevention agenda was lost.

Why is it that Congress' vision of public health reform varied so dramatically from the recommendation of public health experts? A full answer to that question is beyond the scope of this paper, but the question suggests a few promising areas for future discussion and research.

First, perhaps Congress was concerned about potential political backlash. Discussions of public health disparities and population-based approaches to public health can easily be caricatured as "socialistic" or "European"—both powerful epithets in the current political environment.[109] With passage of the insurance-related provisions of the Act already under attack as "government-run healthcare," perhaps the authors of the Act were wary to include any provisions that could add more fuel to fire.[110] Similarly, perhaps the Democratic authors of the Act narrowly framed the public health provisions in the (ultimately unfulfilled) hope that some more conservative members of Congress would be willing to support them.

Secondly, as noted in the introduction, obesity-related conditions, alcohol use, and tobacco consumption are the major public health—and heath care—challenges of our era. What these three public health issues have in common is that behind each issue is powerful industry with a strong financial interest in making the public *less* healthy: the food industry (including the fast-food industry and the junk/snack

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[109] *See* Hendrick Hertzberg, *Like, Socialism*, NEW YORKER, Nov. 3, 2008, at 45 (noting a history of Republicans denouncing progressive legislation as "socialism," as well as political attacks characterizing Barack Obama as a socialist).

[110] *See* Nicholas D. Kristof, *This Time, We Won't Scare*, N.Y. TIMES, June 11, 2009, at A31 (discussing television ads denouncing health care reform as "government-run health care").

food industry), the alcohol industry, and the tobacco industry. These industries, which all have powerful lobbying arms in Washington and contribute heavily to political campaigns, have a strong incentive to promote public health "solutions" that focus attention on the choices of individual consumers and minimize the role of the industries themselves.[111] Their lobbyists may have played a role in either shaping these provisions or limiting their reach.

Third, either as a result of "deep capture" by corporate interests or the general cultural dominance of the individualist/biomedical perspective, it may be that broader, population-based approaches were never seriously contemplated by the authors of the Affordable Care Act. Paradigms, by their nature, shape conceptions of the source of a particular problem and the scope of possible solutions.[112] The dominance of an individualist perspective in American society, as compared to the more communal perspective of other cultures, has been much discussed elsewhere by philosophers, historians, sociologists, and legal scholars.[113] In short, the vision of autonomous individuals bettering themselves through their own efforts (pulling themselves up by their own "bootstraps") is deeply engrained in American thought. Consequently, it is no surprise that policy solutions are framed around that archetype. It is surely an exaggeration to say that Congress is unwilling to consider broader, communitarian solutions, but it does seem that policy options that focus responsibility on individual decision-makers is the most natural and comfortable starting point for policy-makers in the U.S.

Finally, it may be that legal scholars have not yet taken the work of public health experts and laid the legal theoretical groundwork for a population-based approach to public health policy. As Wendy Parmet notes, the professional training of attorneys—a training shared by

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[111] *Cf.* Michele Simon, *Can Food Companies Be Trusted to Self-Regulate? An Analysis of Corporate Lobbying and Deception to Undermine Children's Health*, 39 LOY. L.A. L. REV. 169, 170 (2006) (detailing food industry lobbying efforts aimed at defeating state and local bills addressing school nutrition).

[112] THOMAS S. KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS 37 (3d ed. 1996).

[113] *See, e.g.*, ROBERT N. BELLAH ET AL., HABITS OF THE HEART 143 (3d ed. 2008) (writing that "[i]ndividualism lies at the very core of American culture" and is "basic to American identity"); MICHAEL J. SANDEL, DEMOCRACY'S DISCONTENT: AMERICA IN SEARCH OF A PUBLIC PHILOSOPHY 6 (1996) ("In recent decades, the civic or formative aspects of our politics has largely given way to the liberalism that conceives persons as free and independent selves, unencumbered by moral or civic ties they have not chosen."); Chunlin Leonhard, *A Legal Chameleon: An Examination of the Doctrine of Good Faith in Chinese and American Contract Law*, 25 CONN. J. INT'L L. 305, 324-326 (2010) (discussing cultural differences between the United States and China and the emphasis on individualism in U.S. culture).

many members of Congress and their staffs—is somewhat antithetical to the public health perspective. "[W]here public health focuses on the interests of populations, lawyers are expected to represent the interests of individual clients, because the legal profession assumes that the common good will emerge from the clash of individual interests in an adversarial system."[114] Parmet's groundbreaking recent book tries to confront the individualist notions deeply engrained in legal practice and legal doctrine, arguing that a "population-based legal analysis" derived from public health scholarship should be applied to a wide range of legal issues (just as scholars of law and economics have successfully argued that economic theory should inform legal thought).[115] Scholarship building on the foundation established by Parmet may help to both change legal norms and provide a stronger theoretical basis for legal interventions that reflect the public health perspective.[116]

All of these issues are ripe topics for further development. For the present, however, we are left with a health care law that will broadly expand access to heath care without taking effective action to reduce the causes of our most expensive chronic diseases. As the cost-related pressures on the health care system inevitably continue to grow, Congress may have an opportunity in the near future to reconsider its approach to preventive health. If so, hopefully it will have the insight and the political courage to follow the guidance of public health experts and enact policy provisions reflecting a broader understanding of preventive health.

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[114] PARMET, *supra* note 9, at 30.

[115] *See id.* at 51-59.

[116] Another promising strain of scholarship is the work of "critical realists" such as Jon Hanson and David Yosifon. Their work not only notes that individual choices are heavily influenced by the context in which they are made, but they also emphasize that market actors have an incentive to exploit these features of human decision-making. For example, David Yosifon writes that "[t]he competitive pressures of the market will compel profit-maximizing corporations to discover and exploit methods of exercising unseen situational influence over consumer behavior, in the same way that market forces compel firms to devise and employ the most efficient forms of business organization." Yosifon, *supra* note 29, at 518 ("Because the market will drive firms in this direction, rewarding with profit firms that do it and rendering bankrupt those that do not, corporations may come to engage in manipulative situational influence vis-a-vis consumers even without any human beings within the corporation consciously desiring to do so."). Thus, they stress the need for policy interventions and legal doctrines that focus on altering corporate conduct. *See also* Benforado et al., *supra* note 25; Jon D. Hanson & Douglas A. Kysar, *Taking Behavioralism Seriously: A Response to Market Manipulation*, 6 ROGER WILLIAMS U. L. REV. 259 (2000); Yosifon, *supra* note 22.